



October 31, 2011

The Honorable Kathleen Sebelius  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

Re: Request for Information Regarding State Flexibility to Establish a Basic Health Program

Dear Madame Secretary:

Thank you for the opportunity to provide comments on your request for information on the Basic Health Program. Our comments are guided by nearly two decades of experience with our MinnesotaCare program which is very similar in nature to the description of the Basic Health Program in the ACA. Our comments are also informed by actuarial and economic modeling work that we have conducted with Exchange Planning Grant funds.

Our MinnesotaCare program provides health care coverage for children, parents, and childless adults with incomes generally up to 275% of the federal poverty level (FPL) that are not eligible for employer-based coverage. The benefit set is similar to that of Medicaid, with some limitations and cost sharing. Enrollees in the program are also subject to premiums similar to that specified in the ACA for premium tax credits. The MinnesotaCare program is administered by the Department of Human Services (DHS), which is our Medicaid agency. DHS contracts with managed care plans to administer the benefit set and establish provider networks with payment rates similar to Medicaid.

We have recently received preliminary enrollment, risk mix, and financial results from actuarial and economic modeling of the Basic Health Program by Jonathan Gruber of MIT and Bela Gorman of Gorman Actuarial funded under our Exchange Planning Grant. This modeling work is based on Minnesota-specific claims experience, benefit levels, premiums, enrollment, demographic, and health status information collected from our health insurers, Minnesota high risk pool, Medicaid agency, and Minnesota Health Access Survey. The modeling results show that the population between 133% and 200% FPL is sicker on average than the population over 200% FPL. This finding raises questions about the impact on premium levels in the Exchange and how the 95% of premium tax credits and cost reductions will be calculated and transferred to a state to operate a Basic Health Program.

In addition to these questions that most states are contemplating, Minnesota has other questions related to timing. In states like Minnesota that operate a state-based program similar to a Basic Health Program, is it extremely important that regulations for the Basic Health Program be promulgated and finalized as soon as possible so that these states can decide what to do with state-based programs and whether a state-based program should be transitioned to a Basic Health

Program. States with existing similar programs do not have the luxury of delaying consideration of a Basic Health Program until 2015 or later.

We ask that the U.S. Department of Health and Human Services (HHS) release Basic Health Program regulations as soon as possible that incorporate four key provisions:

- First, we ask that HHS specify the methodology for calculating the 95% and in doing so, incorporate methodologies to adjust for the differential risk mix between the Basic Health Program and individual market/Exchange populations.
- Second, we ask that HHS consider a more extensive definition of “benefits” so that the administrative costs of the program could be funded by the 95% under the law. The law specifies that the 95% may only be used to reduce premiums or cost-sharing or to provide additional benefits for eligible individuals in a Basic Health Program. Administrative costs provide “benefits” for eligible individuals through the general existence of the program that could provide enhanced benefits, reduced premiums, and/or reduced cost-sharing.
- Third, we ask that HHS allow the utmost flexibility for states to establish a Basic Health Program as allowed under the law.
- Fourth, we ask that HHS establish an expedited certification process for the Basic Health Plan – especially for states with existing similar state programs – so that if states with existing similar programs wish to establish a Basic Health Program that one can reasonably be certified for enrollment in 2014. We suggest that HHS consider issuing certification regulations in a phased approach, where the first phase of the regulations could be limited to addressing existing state programs that already meet, or nearly meet, the minimal statutory requirements for a Basic Health Program.

In addition to these general comments, we have also enclosed responses to some of the specific questions posed in your request for information. Again, thank you for the opportunity to provide comments.

Sincerely,



Lucinda Jesson, JD  
Commissioner  
Department of Human Services



Mike Rothman, JD  
Commissioner  
Department of Commerce



Edward P. Ehlinger, MD, MSPH  
Commissioner  
Department of Health

## **MN COMMENTS ON BASIC HEALTH PROGRAM REQUEST FOR INFORMATION**

***A1. What are some of the major factors that States are likely to consider in determining whether to establish a Basic Health Program? Are there additional flexibilities, advantages, costs, savings or challenges for the State and/or consumer that would make this option more or less attractive to States? If so, what are they?***

Minnesota is in the very early stages of discussing issues related to the Basic Health Program and the Exchange. In order to continue this discussion in depth and make decisions regarding whether to do a Basic Health Program and if so, how to structure the program, it is important that regulations regarding the Basic Health Program be promulgated as soon as possible. Listed below are some initial issues under consideration in Minnesota:

- Minnesota has recently received preliminary actuarial and economic modeling results regarding the Basic Health Program. The results show that the population between 133% and 200% FPL is sicker on average than the population over 200% FPL. This finding raises questions about the impact on premium levels in the individual market and the Exchange and how the 95% of premium tax credits and cost reductions will be calculated and transferred to a state to operate a Basic Health Program. It is important that the methodology for calculating the 95% adjust for the differential risk mix between the Basic Health Program and individual market/Exchange populations for this program to be financially viable for states.
- The Basic Health Program could act as a bridge between Medicaid benefits and private health benefit plans in the Exchange. A state could structure the benefits, cost-sharing, and/or premiums to be between those of Medicaid and the Exchange to help individuals transition between public and private coverage. One benefit of this approach is that the benefit levels could exceed those in the private market and the state would not be financially liable under the ACA for the cost of the benefits in excess of the Essential Benefit Set. In order to consider these issues in more detail, it is important that regulations regarding the Essential Benefit Set be released soon so that states can assess the difference between Medicaid benefits and the Essential Benefit Set. It is also important that the methodology to calculate the 95% be released soon so that states can determine the level of financial resources that would be available for benefits, cost-sharing, premiums, and provider rates. One issue of particular interest to states and stakeholders will be the level of provider rates that would be possible and how these rates may impact access to care and cost-shifting to premium rates in the private market.
- Another issue of interest to states is whether the 95% can be used to pay for the administrative costs of a Basic Health Program. We ask that HHS consider a more extensive definition of “benefits” so that the administrative costs of the program could be funded by the 95% under the law. The law specifies that the 95% may only be used to reduce premiums or cost-sharing or to provide additional benefits for eligible individuals in a Basic Health Program. Administrative costs provide “benefits” for eligible individuals in multiple ways including the general existence of the program and in the

administration of the program which could encourage health improvement through payment reform, quality measurement, disease management, care coordination, etc.

- In addition to these issues that most states are contemplating, Minnesota has other equally important questions related to timing. In states like Minnesota that operate a state-based program similar to a Basic Health Program, is it extremely important that regulations for the Basic Health Program be promulgated and finalized as soon as possible so that these states can decide what to do with state-based programs and whether a state-based program should be transitioned to a Basic Health Program. States with existing similar programs do not have the luxury to delay consideration of a Basic Health Program until 2015 or later. We ask that regulations for the Basic Health Program provide for the maximum level of flexibility allowed under the law and that HHS establish an expedited certification process for the Basic Health Program so that states with existing similar programs that choose to transition an existing program to a Basic Health Program could reasonably do so by 2014.

***A4 and E3. Are States that are exploring the Basic Health Program considering implementation for 2014, or for later years? The statute specifies that in developing the financial methodology for the Basic Health Program, the determination of the value of the premium tax credits and cost-sharing reductions should take into consideration the experience of other States. What information would be most helpful to inform this methodology? Should implementation of the Basic Health Program be postponed until other States' experiences are available?***

In states like Minnesota that operate a state-based program similar to a Basic Health Program, is it important that a Basic Health Program option be available for consideration for operation in 2014. States with existing similar programs may find it difficult to halt a state-based program for a few years and then restart it. It is important that states with existing similar programs have all of the necessary information available as soon as possible in order to make a decision about the Basic Health Program prior to 2014.

Although the law specifies that the experience of other states should be taken into consideration to determine the value of the tax credits and cost-sharing reductions, it will be most important for the calculation of the 95% to take into account the actual differential risk mix between the Basic Health Program and individual markets/Exchange populations within individual states. States will establish their Exchange and Basic Health Programs differently so a comparison between states will not likely provide more than directional information for risk mix comparison.

***D2. What is the expected impact of a Basic Health Program on plans participating in the Exchange in terms of risk profile, enrollment, and premium stability? What is the expected impact on overall coverage?***

Minnesota has recently received preliminary actuarial and economic modeling results regarding the Basic Health Program and the results show that the population between 133% and 200% FPL is sicker on average than the population over 200% FPL. This finding indicates that premiums in

the individual market and the Exchange would be higher if a state does not choose to have a Basic Health Program. This finding will be of particular concern for those over 400% FPL not receiving premium tax credits and employees of small employers with a defined contribution for purchase of portable individual market coverage.

***E1 and E2. The statute specifies that amounts in the trust fund may only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within a Basic Health Program. What options are States considering for reducing premiums and cost-sharing, or providing additional benefits? What, if any, guidance is needed on this provision? What are the likely administrative costs for a Basic Health Program? What factors, especially in terms of resources, are likely to affect a State's ability to establish a Basic Health Program? How are States likely to fund the costs associated with establishing and administering a Basic Health Program?***

We ask that HHS consider a more extensive definition of “benefits” so that administrative costs of a Basic Health Program could be eligible for funding from the 95% calculation of premium tax credits and cost-sharing reductions that would have been spent on this population if they purchased health benefit plans through an Exchange. The law specifies that the 95% may only be used to reduce premiums or cost-sharing or to provide additional benefits for eligible individuals in a Basic Health Program. Administrative costs provide “benefits” for eligible individuals through the general existence of the program which could provide increased benefits, lower premiums and/or lower cost-sharing and in the administration of the program which could encourage health improvement through payment reform, quality measurement, disease management, care coordination, etc. If the 95% cannot be used for administrative costs, states with tight budgets and deficits may not be able to afford to pay for the administration of the program that could provide “benefits” to lower-income consumers.

***E4 and E7. Other than those listed in the statute, what factors should be considered when establishing the methodology for determining the amount of Basic Health Program funding to States? How should the Federal government implement this calculation? What methods should be considered to measure and monitor compliance with the 95 percent cap on funding? How should CMS implement the provisions in Section 1331(d)(3)(B) of the Affordable Care Act regarding corrections to overpayments made in any year?***

Given the potential for differential health status between the Basic Health Program and individual market/Exchange populations, it is important that the methodology for calculating the 95% incorporate methodologies to adjust for the differential risk mix. Although the ACA does not specifically include the Basic Health Program in risk adjustment for the individual and small group markets, it does specify that “[The Secretary] shall take into account all relevant factors necessary to determine the value of the premium tax credits and cost-sharing reductions that would have been provided to eligible individuals.... including the age and income of the enrollee, whether the enrollment is for self only or family coverage, geographic differences in average spending for health care across rating areas, the health status of the enrollee for purposes of determining risk adjustment payments and reinsurance payments that would have been made if the enrollee had enrolled in a qualified health plan through an Exchange.”

We recommend that HHS calculate the 95% based on an actuarial assessment of the difference in risk mix between the Basic Health Program and individual market/Exchange populations. This can be accomplished by collecting and comparing the claims experience of the two populations. Claims data is already proposed to be available for the individual market for risk adjustment, so this method would only require additional collection of claims data for the Basic Health Program population – this would be collected for this population in the individual market if a state did not do a Basic Health Program. A reconciliation period could occur at the end of the year to address over and underpayments within an established range. It may also ease administrative burden for both the states and HHS to recognize that the calculations are subject to some uncertainty and therefore not reconcile differences within +/- 1%.

For states with an existing all payer claims database such as Minnesota, we suggest that the risk assessment and funding methodology could be implemented on a prospective basis and include a year-end reconciliation. For the uninsured for which no claims data would exist, information from enrollee questionnaires collected during the open enrollment period could be used. For states without claims databases in the first year, enrollee questionnaires could be used initially in combination with concurrent claims data and experience in other states with existing claims databases. This methodology could be transitioned over time to a prospective model for these states. We ask that the collection of claims data and enrollee questionnaires and actuarial assessment be funded with federal funds outside of the 95%, as the Secretary is charged with developing a methodology. A simple example of the methodology is provided below:

	<u>Basic Health Program</u>	<u>Individual Market/Exchange</u>
Actuarial Assessment of Risk Mix (using claims data and enrollee questionnaires):	1.12	1.00
PMPY Premium Tax Credits and Cost-Sharing Reductions (assuming 133-200% population, tax credits from open enrollment, and actuarial estimate of cost-sharing)	\$3,360	\$3,000
95% Tax Credits + Cost-Sharing	\$3,192	
End Year Risk Mix (only used during transition to prospective method)	1.14	1.00
End Year PMPY Premium Tax Credits and Cost-Sharing Reductions (assuming 133-200% population for tax credits and cost-sharing)	\$3,306	\$2,900
End Year 95% Tax Credits + Cost-Sharing	\$3,140.70	
Difference PMPY	<u>\$51.30</u>	
Reconciliation (if above/below 1% )	\$19.89 PMPY returned to federal government	

***G1 and G2. What process should the Secretary use to certify or recertify Basic Health Programs? How should this process be similar to or different from Exchange certification? What should be considered when developing an oversight process for the Basic Health Program?***

In keeping with the intent of the ACA to afford states substantial flexibility, we ask that regulations for the Basic Health Program provide for the maximum level of state flexibility allowed under the law. We also ask that HHS establish an expedited certification process for the Basic Health Program as soon as possible prior to 2014 so that states with existing similar programs that choose to transition an existing program to a Basic Health Program could reasonably do so by 2014. Ongoing oversight of the program could require states to provide a 30-day notice of changes to the program in lieu of a filing for approval, giving HHS the opportunity to raise concerns if it believes a change is not consistent with the law. In addition, states could also be required to undergo an in depth program review every three to five years.

We also ask that HHS consider issuing certification regulations and guidance in a phased approach. The first phase of the regulations could be limited to addressing existing state programs that already meet, or nearly meet, the requirements for a Basic Health Program. This phase of the regulations could articulate the minimal statutory requirements necessary to transition an existing program to a Basic Health Program. The second phase of the regulations could articulate the expanded program requirements for newly established Basic Health Programs. The second phase would also describe the options and timelines for existing Basic Health Programs that were subject to phase one regulations. Such a phased approach would help states to maintain existing programs and still allow HHS adequate time to fully develop the final requirements.